Area Regional Transit Paratransit Eligibility Medical Verification Forms

Please ask your Florida Licensed/Certified Heath Care Provider to complete the medical form that best describes your need for Paratransit services.

Note to Medical Provider: *By completing and signing the medical documents, you certify to the truth and accuracy of the information provided on the application, to the best of your professional knowledge. The Americans with Disabilities Act of 1990 requires ART to provide services to persons who are unable to use the fixed route bus system due to a disability. The information you provide will allow ART to make an appropriate evaluation of your clients' eligibility.*

To qualify for Paratransit service, an individual must meet the criteria as set forth in one of the following categories:

Category 1: Individuals who, as a result of a physical or mental impairment (including visual impairments) and without the assistance of another individual (except the operator) cannot board, ride or disembark from an accessible transit vehicle.

Category 2: Individuals who can independently use accessible vehicles, but none are available on their route.

Category 3: Individuals who have a specific impairment-related condition that prevents them from independently getting to/from a stop.

Located at www.slcart.org, you may submit additional completed verification forms as applicable:

Form A - General Medical
Form B - Vision
Form C - Epilepsy or Seizure Disorders
Form D - Cognitive or Mental Health Conditions

ATTACH A COPY OF YOUR VALID FLORIDA DRIVER'S LICENSE/ID OR CURRENT GOVERNMENT ISSUED ID WITH THIS APPLICATION.

Area Regional Transit Paratransit Eligibility

Form C: Epilepsy or Seizure Disorder

To be completed by a Licensed Health Care Provider

Applicant's Name: _____ Date of Birth: _____

1. Type of Seizure: _____
2. Seizure Frequency: _____
3. Does the seizure alter consciousness or awareness? ☐Yes ☐ No
4. Please specify the behaviors exhibited during/following the applicant's seizure? _____

   _____
5. Would applicant be able to travel independently on fixed route buses if they are medication compliant? ☐Yes ☐ No
6. Is applicant's functional limitation permanent? ☐ Yes ☐ No
   If no, expected duration? # of Months_____ # of Years_____
7. For safety reasons, does the applicant need to travel on ART at all times, with a PCA? ☐ Yes ☐ No If yes, please explain:

   _____

   _____
8. For safety reasons, can applicant be left unattended at pickup or drop-off locations? ☐ Yes ☐ No If no, please explain:

   _____

   _____

I certify the information provided above is correct.

_____ _____

Signature of Licensed Health Care Provider Date

Clearly print your contact information below:

Name: _____ Board cert. # or Lic. #:_____

Phone #: _____ Fax #: _____

Business address: _____